

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106148	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2025
NAME OF PROVIDER OR SUPPLIER Luxe at Jupiter Rehabilitation Center (the)		STREET ADDRESS, CITY, STATE, ZIP CODE 674 Pioneer Road Jupiter, FL 33458	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29151</p> <p>Based on record review, policy review and interview, the facility staff failed to report an allegation of neglect for 1 of 2 sampled residents reviewed for neglect (Resident #2).</p> <p>The findings included:</p> <p>Review of the facility policy titled, Abuse, Neglect, Exploitation, Misappropriation, Mistreatment, and Injury of Unknown Origin (ANEMMI) revised on 01/2024 documented the following:</p> <p>Standard: Our residents have the right to be free from abuse, neglect, misappropriation of resident property, exploitation, and mistreatment. Reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property and mistreatment, collectively known and referred to as ANEMMI and hereafter defined, will not be tolerated by anyone, including staff, residents, volunteers, family members, legal guardians, resident representatives, friends or any other individuals.</p> <p>The Health Center Administrator is responsible for assuring that Residents' Rights of personal privacy, confidentiality and dignity will be respected for all aspects of care and services and that resident safety, including freedom from risk of ANEMMI, holds the highest priority.</p> <p>Definitions</p> <p>2. NEGLECT: The failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or mental illness. Neglect occurs when the facility is aware of, or should have been aware of, goods or services that a resident(s) requires but a facility fails to provide them, to the resident(s), that has resulted in or may result in physical harm, pain, mental anguish, or emotional distress. Neglect includes cases where the facility's indifference or disregard for resident care, comfort, or safety, resulted in or could have resulted in, physical harm, pain, mental anguish or emotional distress.</p> <p>Identification: Any resident event that is reported to any staff by resident, family, other staff or any other person will be considered as possible ANEMMI if it meets any of the following criteria:</p> <p>a. Any indication of possible willful infliction of injury to include unexplained bruising.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>b. Unreasonable confinement, to include unwanted restriction of access to all resident areas of the building.</p> <p>c. Any resident or family complaint of physical harm, pain or mental anguish resulting from willful infliction from others.</p> <p>d. Any complaint of deprivation by an individual caregiver of goods and services necessary to attain or maintain physical, mental, and psychological well-being to include toileting issues.</p> <p>e. Any complaint of the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or families or within their hearing distance.</p> <p>f. Any complaint of sexual harassment, sexual coercion, or sexual assault.</p> <p>g. Any instances of hitting, slapping, pinching, or kicking or other potentially harmful action.</p> <p>h. Any behavior control strategy involving corporal punishment.</p> <p>Any complaint of humiliation, harassment, threats of punishment or deprivation.</p> <p>j. Any allegation of misappropriation of resident property.</p> <p>REPORTING AND RESPONSE</p> <p>Policy: All allegations of possible ANEMMI will be immediately reported to the Abuse Hotline by the Administrator or Designee and will be evaluated to determine the direction of the investigation.</p> <p>Procedure: Any and all staff observing or hearing about such events must report the event immediately to the Administrator, Immediate Supervisor AND one of the following: Directors of Nursing, ANEMMI Prevention Coordinator, or Risk Manager, so that appropriate reporting and investigation procedures take place immediately. It will also be reported to other officials in accordance with State and Federal Regulations.</p> <p>Any and all employees are empowered to initiate immediate action as appropriate by contacting the Abuse Hotline at [PHONE NUMBER] if they witness such an event or have reasonable cause to suspect such an event has indeed occurred. However, contacting the Abuse Hotline does not alleviate the responsibility to immediately notify the Administrator, Immediate Supervisor AND one of the following: Director of Nursing, ANEMMI Prevention Coordinator, or Risk Manager.</p> <p>A. IMMEDIATE REPORT</p> <p>In accordance with CFR 483.12(c)(1), with response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the vents that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and Adult Protective Services where state law provides for jurisdiction in long term care facilities) in accordance with State law through established procedures.</p> <p>The ANEMMI Prevention Coordinator will also submit to The Agency for Health Care Administration (AHCA) Federal Immediate/5-Day Report.</p> <p>B. REPORT OF INVESTIGATION (Five Day Report):</p> <p>The facility ANEMMI Prevention Coordinator will send the result of facility investigations to the State Survey Agency within five working days of the incident. This will be completed using the same AHCA Federal/Five day report.</p> <p>C. REPORTING OF A SUSPICION OF CRIME (EJA)</p> <p>The facility will annually notify covered individuals of their reporting obligations if there is a reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from the facility. Covered individuals that have reporting obligations under the Elder Justice Act are owners, operators, employees, managers, agents and contractors of long-term care facilities.</p> <p>Review of the facility's incident logs, grievances and reportable logs dated 10/24 thru 01/25 conducted on 01/21/25 revealed no entries related to Resident #2.</p> <p>On 01/21/25 at 3:08 PM a request for laboratory test results for Resident #2 was made, the Regional Nurse Consultant informed the surveyor that the facility had a soft file addressing the concerns reported by the hospital regarding Resident #2's care.</p> <p>Interview with Regional Nurse Consultant on 01/22/25 at 10:57 AM revealed on 01/17/25, the facility's Marketing Director sent her an email with a picture of Resident #2's wound, located on his foot. The email was sent due to concerns from the hospital regarding the condition of the resident's wound. The Regional Nurse Consultant stated that she had attempted to contact the hospital, but no one returned her call. Then she discussed the concern with the rest of the clinical team, a soft file was created, they did a deep dive, reviewed the record and implemented a performance improvement project for skin and wounds.</p> <p>The facility completed a timeline and determined they provided appropriate care and documented interviews including the hospitalist and noted he had no personal knowledge of maggots in the resident's wound.</p> <p>Record review revealed the hospital records provided the following information:</p> <p>Resident #2 presented to the emergency department on 01/15/25 at 8:04 PM due to Altered Mental Status.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Hospitalist notes dated 01/16/25 documents the following: According to reports, the patient was nonverbal on arrival apparently was sent in secondary to altered mental status and decreased function. Patient found to be in septic shock, have bilateral lower lobe pneumonia as well as urinary tract infection and elevated Troponin. He was admitted to the intensive care unit, started on Levophed drip and his wounds were dressed. Patient was found to have live maggots in the dressings of his right hip wound. Following this, wound care did see the patient and took multiple pictures and addressed his multiple wounds.</p> <p>Interview with the Regional [NAME] President of Marketing (RVPM) conducted on 01/22/25 at 1:40 PM, revealed on 01/17/25 he received an email from a staff member from the Medical Director's office. The staff sent an email alleging the hospital was concerned with the lack of care to Resident #2's wounds. The RVPM stated that he lacks clinical expertise and forwarded the email to the clinical consultant.</p> <p>During an interview with the Nursing Home Administrator (NHA) and the Regional Nurse Consultant (RNC) conducted on 01/23/25 at 3:36 PM, the leadership was asked why the facility did not report the allegation of neglect regarding Resident #2's wounds. The NHA explained she did not receive allegations of neglect or pictures from the hospital. The information filtered thru the marketing team and the corporate leadership. The photos were shared by the practitioner with the Director of Nursing, but up to now, she has not seen them. The Regional Nurse Consultant stated they received the pictures from the hospital and the wounds seemed the same as to the information they had in the medical record, they did not identify anything wrong with the wound. When asked as to why the event was investigated, the RNC explained they did complete a thorough investigation, interviews and timeline and determined the facility provided care for Resident #2's wound, and this was done to respond to the hospital concerns. The NHA added the facility was compiling this file to address the issue with the hospital but no one from the hospital called them with allegations of neglect. The leadership was asked again as to why the concerns regarding the condition of the resident's wounds were not identified as an allegation of neglect, which is defined as failure to provide necessary care and services and acknowledged that is possible that they waited too long, they were trying to address the issue with the hospital and their investigation revealed the resident received appropriate care.</p> <p>Review of facility documents including reportable event and incident logs failed to provide evidence the facility identify the hospital concerns regarding Resident #2's care to his wound as an allegation of neglect.</p>

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29151</p> <p>Based on observation, record review and interview, the facility staff failed to provide necessary treatment and services to promote healing and prevent infection of existing pressure wounds. The failure affected 2 of 6 sampled residents, Resident #2, who arrived at the hospital with maggots in the wound and Resident #6 who did not receive the prescribed treatment for tissue granulation and autolytic debridement.</p> <p>The findings included:</p> <p>1) Clinical record review revealed Resident #2 was admitted to the facility on [DATE] with diagnoses of Dementia and Heart Failure.</p> <p>Review of the Minimum Data Set with reference date of 12/31/24 documented the resident was assessed as moderately impaired for skills of daily decision making, had a urinary catheter, was incontinent of bowel and had an unstageable pressure wound, present on admission.</p> <p>Review of care plan dated 11/08/24 documented the resident has a pressure ulcer to the right hip. The goal documented the resident's pressure ulcer will show signs of healing as evidenced by decrease in size, improved appearance, and be free from infection by/through review date. Interventions included the following: Administer medications and treatments as ordered, monitor for signs of infection, nutritional approaches to maintain optimal wound healing, obtain and monitor lab/diagnostic work as ordered and provide incontinent care after each incontinent episode, apply barrier cream as needed.</p> <p>Review of physician's order dated 01/08/25 documented, Treatment: Cleanse right hip with normal saline or wound cleaner, apply skin prep to peri-wound, pack lightly with Honey gel, cover with bordered gauze and change three times a week (Monday, Wednesday, and Friday for wound) and as needed loss of integrity.</p> <p>Further record review revealed on 01/15/25 Resident #2 was transferred to the local hospital due to altered mental status between the hours of 7 PM to 8 PM.</p> <p>An interview with the Wound Nurse conducted on 01/22/25 at 12:17 PM revealed the nurse took over wound care duties on 01/14/25. Resident #2 wounds included an intact blister to the heel and an open wound to the hip. Wound Nurse stated she performed the wound care on 01/14/25 and 01/15/25 and did not notice any signs of infection or foreign bodies. On 01/15/25 the dressing was done around 7 AM. The Wound Nurse stated she had verbal training with the Director of Nursing upon agreeing to the position and that she is receiving additional training today with the certified Wound Nurse. As a floor nurse she has performed wound care, and it entailed following the physician's orders, no specific training was provided.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>An interview with the Physician Assistant (PA), Wound Care Provider, conducted on 01/22/25 at 1:50 PM revealed her recollection of Resident #2's wounds. The PA rounded on 01/13/25 and the hip wound was clean. The PA was asked what causes maggots in a wound and stated typically if the wound is not taken care of, contamination with feces, urine or other organisms but she is not an expert. She further explained that some providers will use them for therapeutic purposes, but they do not utilize that practice.</p> <p>Review of photographic evidence from the hospital dated 01/15/25 at 10:55 PM indicates the resident's wound to the right hip had a soiled dressing with maggots.</p> <p>An interview with the Risk Coordinator and Director of the Intensive Care Unit on 01/23/25 at 2:16 PM revealed the nurse discovered the maggots when the dressing was removed for skin evaluation upon arrival to the unit and stated the dressing was not dated.</p> <p>Record review revealed the hospital records provided the following information:</p> <p>Resident #2 presented to the emergency department on 01/15/25 at 8:04 PM due to Altered Mental Status.</p> <p>Hospitalist notes dated 01/16/25 documented the following: According to reports, the patient was nonverbal on arrival apparently was sent in secondary to altered mental status and decreased function. Patient found to be in septic shock, have bilateral lower lobe pneumonia as well as urinary tract infection and elevated Troponin. He was admitted to the intensive care unit, started on Levophed drip and his wounds were dressed. Patient was found to have live maggots in the dressings of his right hip wound. Following this, wound care did see the patient and took multiple pictures and addressed his multiple wounds.</p> <p>Review of the personnel files revealed the current Wound Nurse is a Licensed Practical Nurse, with no documented prior wound care experience and it is noted the job description requirement included Registered Nurse License. Please refer to additional evidence validating the lack of competency in the provision of wound care during observation of care involving Resident #6.</p> <p>2) Clinical record review conducted on 01/21/25 revealed Resident #6 was readmitted to the facility on [DATE].</p> <p>Review of the Minimum Data Set assessment with reference date of 11/15/24 documented the resident was assessed as independent with skills for daily decision making, has urinary catheter, ostomy, and multiple wounds, three stage III, one stage IV, and one unstageable pressure ulcers.</p> <p>Review of the care plan dated 08/01/24 titled, Resident has a pressure ulcer, right and left ischium, posterior neck and mid back related to traumatic injury, documented interventions as administer treatments as ordered by the physician and monitor for signs of infection.</p> <p>Review of physician orders dated 11/29/24 documented as follows:</p> <p>Treatment: Cleanse left ischial with Dakin's 1/4 strength, pat dry, apply skin prep to peri-area of the wound, then apply Collagen Powder and Calcium Alginate and cover with silicone foam dressing daily and as needed (PRN) until resolved.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Cleanse right ischial with Dakin's 1/4 strength, pat dry, apply skin prep to peri-area of the wound, then apply Collagen Powder and Calcium Alginate and cover with silicone foam dressing daily and PRN until resolved.</p> <p>Cleanse sacrum with Dakin's 1/4 strength, pat dry, apply skin prep to peri-wound, collagen powder, calcium alginate and cover with silicone foam dressing daily and PRN.</p> <p>Observation of wound care conducted on 01/21/25 starting at 11:30 AM revealed Resident #6 in bed, alert and oriented and consented to the observation. The Wound Nurse and the Unit Manager prepared supplies for Resident #6, performed hand hygiene and donned protective equipment. Then the Wound Nurse removed the three dressings to the right and left ischium and to the sacrum. After removing the dirty dressing, the Wound Nurse performed hand hygiene, donned clean gloves and proceeded to clean the wounds with Dakin's solution, 1/4 strength, then used the wound cleanser spray, applied to clean gauze and cleansed the skin around the wound that had white residue in between the wounds. The Wound Nurse then performed hand hygiene, donned clean gloves and applied border dressing to each of the three wounds. The Wound Nurse failed to follow physician's orders, the nurse did not apply the prescribed Collagen Powder and Calcium Alginate.</p> <p>An interview conducted on 01/21/25 at 12:18 PM with the Wound Nurse and Unit Manager confirmed the Wound Nurse did not follow the physician's order for wound care, the Wound Nurse failed to apply the collagen powder and calcium alginate to the right and left ischial and the sacral wound.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>29151</p> <p>Based on observation, record review, policy review and interview, the nursing staff failed to implement the facility policy for the storage of nebulizer equipment. The failure affected 1 of 6 sampled residents (Resident #1).</p> <p>The findings included:</p> <p>Record review revealed the facility's policy titled, Respiratory Treatment Administration, last revised 12/2023 documented Nebulizers are administered per physician's orders and nebulizer tubing is stored in a hygienic manner (i.e. labeling bag with date tubing was change). Additional guidelines: Report other information in accordance with facility policy and professional standards of practice.</p> <p>Observation of care conducted on 01/22/25 starting at 9:10 AM revealed Resident #1 was lying in her bed. A nebulizer machine was observed on the nightstand, the nebulizer mask was dirty, stained with yellow substance, and it was inside a plastic bag from a grocery store with a bread label. The mask was connected to the nebulizer machine. The resident's spouse informed the surveyor that the staff does not change the mask and that he put it inside the plastic bag, because they leave the mask on top of the table.</p> <p>On 01/22/25 at 9:20 AM, Staff B, a Licensed Practical Nurse, confirmed the nebulizer mask was not dated, was not sure when it was last changed and confirmed the mask and tubing should not be stored inside of a plastic bread bag from a grocery store, and that she will replace it immediately.</p> <p>Clinical record review conducted on 01/21/25 and 01/22/25 revealed Resident #1 was prescribed on 12/31/24, Ipratropium-Albuterol Solution 0.5-2.5 milligrams/3 milliliters, inhale orally two times a day for Shortness of Breath, the resident has a medical history of Chronic Obstructive Pulmonary Disease.</p> <p>Review of the Minimum Data Set, annual assessment with reference date 12/02/24, documented the resident was assessed as severely impaired for skills of daily decision making, requires extensive assistance with activity of daily living, has shortness of breath when lying flat and is receiving antibiotic medications.</p> <p>Review of the Care Plans dated 11/13/24, documented the resident is at risk for altered respiratory status/difficulty breathing related to episodes of shortness of breath and upper respiratory infection.</p> <p>The interventions include:</p> <p>Monitor for signs of respiratory distress and report to physician: Increased Respirations; Decreased Pulse Oximetry; Increased Heart Rate (Tachycardia); Restlessness; Diaphoresis; Headaches; Lethargy; Confusion; Hemoptysis; Cough;</p> <p>Pleuritic pain; Accessory muscle usage; Skin color changes to blue/grey.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Administer medication/inhalers/nebulizers as ordered.</p> <p>Administer oxygen as ordered. Change tubing, per facility protocol/MD order and PRN. Notify MD as indicated.</p> <p>Review of the medication and treatment administration records dated 01/2025 failed to document when the staff changed the nebulizer tubing/mask and storage bag.</p>